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Scaling up HIV prevention, treatment, care and support

Note by the Secretary-General

The assessment by the Joint United Nations Programme on HIV/AIDS (UNAIDS) of inclusive, country-driven processes for scaling up HIV prevention, treatment, care and support is submitted pursuant to General Assembly resolution 60/224. In that resolution, the Assembly requested UNAIDS and its co-sponsors to assist in facilitating such processes, with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it, including through increased resources, and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV/AIDS and other health issues. The Assembly also requested that UNAIDS submit, for consideration at its sixtieth session, an assessment of these processes, based on inputs received from Member States, including an analysis of common obstacles to scaling up and recommendations for addressing such obstacles, as well as for accelerated and expanded action.

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Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support

Summary

AIDS is one of the greatest leadership challenges of our time. Without urgent and long-term action, the epidemic will continue to take an unacceptable toll of death and suffering in countries and communities throughout the world.

In the 2005 World Summit Outcome (resolution 60/1), world leaders committed to a massive scaling up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it. In July 2005, in the Gleneagles Communiqué, leaders of the Group of Eight countries expressed their strong support for working towards this goal. These ambitious commitments have brought the AIDS response to another historic juncture.

In response to the request of the General Assembly contained in its resolution 60/224, the secretariat and co-sponsors of the Joint United Nations Programme on HIV/AIDS (UNAIDS) have helped to facilitate inclusive, country-led processes to develop practical strategies for moving towards universal access. In the present report, UNAIDS assesses those processes. The assessment includes an analysis of common obstacles and recommendations for overcoming them, through an exceptional approach in which HIV prevention, treatment, care and support are integrated with broader health and social services such as programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, nutrition, orphans and vulnerable children, as well as formal and informal education.

Thousands of people from all walks of life have mobilized to seize this extraordinary opportunity:

(a) More than 100 low- and middle-income countries have held broad public debates about what needs to be done to turn back the epidemic;

(b) Seven regional consultations were held, under the leadership of the African Union, the Caribbean Community Secretariat and Pan-Caribbean Partnership against HIV/AIDS, the Commonwealth of Independent States and the Latin American Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean, and with the participation of the Association of Southeast Asian Nations and the South Asian Association for Regional Cooperation;

(c) The UNAIDS secretariat convened a multipartner Global Steering Committee to identify global-level actions, to provide insights and inspiration and to act as a political sounding board.

The country processes build on earlier efforts, such as the "3 by 5" initiative to expand HIV treatment. The number of people on antiretroviral therapy in low- and middle-income countries nearly doubled in 2005 alone, from 720,000 to 1.3 million. However, there were 4.9 million new HIV infections in 2005 — the vast majority occurring in low- and middle-income countries. At this rate of new infections, the Millennium Development Goal of halting and reversing the spread of HIV by 2015

will be unattainable and the world will only move farther away from universal access.

A renewed emphasis on HIV prevention is critically needed. Scaling up prevention is essential in its own right to prevent the suffering of individuals, to alleviate the impact of AIDS and to address the spiralling costs of HIV treatment. The internationally agreed UNAIDS policy paper "Intensifying HIV prevention" provides a framework for strengthening evidence-informed HIV prevention within a comprehensive response, including treatment, care and support for those infected and affected by HIV. The success of the movement towards universal access will depend largely on whether leaders can mount a massive social mobilization to dramatically decrease the number of new HIV infections, along with urgent efforts to increase HIV treatment coverage for millions of people already infected.

AIDS is an exceptional threat to global progress. AIDS destroys the social fabric of many communities and countries. The epidemic is exceptional because of its complexity, requiring policymakers to address deep social taboos concerning sexual behaviours, drug use, power relations between women and men, poverty and death.

Diverse definitions for the phrase "as close as possible to universal access" emerged from the consultations. The provision of HIV prevention, treatment, care and support to all who need them is an extremely ambitious goal. The concept of universal access implies that all people should be able to have access to information and services. Scaling up towards universal access should be equitable, accessible, affordable, comprehensive and sustainable.

Consultation participants widely agreed that greater accountability is required to stimulate urgent and sustainable progress. Countries are ready to set their own ambitious targets, based on what they can and should achieve by 2010. The UNAIDS secretariat and the World Health Organization will provide countries with a small set of key indicators and guidelines to help set national targets for measuring progress towards universal access.

A number of key challenges that stand in the way of scaling up towards universal access emerged from the consultations. Financing to implement AIDS plans is inadequate, and funding is often unpredictable and of too short duration, reducing the ability of Governments to sustain the delivery of AIDS programmes.

In many low-income countries, scaling up requires breaking the downward spiral of human resource depletion, in which insufficient numbers of staff are being trained to replace those lost. The consultations decried the fact that HIV-related commodities are not affordable and readily available, while new technologies are badly needed.

The consultations described the fear — fed by widespread stigma and discrimination, violence against women, homophobia and other HIV-related human rights abuses — that discourages people from seeking the information and services that will protect them from HIV infection or determine whether they are already carrying the virus. Stigma and discrimination can impede people living with HIV from adopting safe behaviours and seeking access to HIV treatment and care programmes. These factors too often block policymakers from ensuring that young

people have the capacity to make informed decisions to protect themselves from HIV infection.

The regional consultations underscored that there is no single AIDS epidemic. Rather, the epidemics coursing through the world are varied, both among and within regions, and even within individual countries. Because the epidemics vary in their intensity, pace and impact, locally tailored prevention, treatment, care and support responses need to be developed.

On the basis of these challenges and the solutions proposed in the country, regional and global consultations, UNAIDS has identified six major requirements for reaching our common goal. For each, specific recommendations are included within the main body of the present assessment. Those recommendations will help overcome major obstacles impeding countries from scaling up integrated AIDS programmes and moving towards universal access. It will not be easy to break the vicious cycle of new HIV infections, put millions of people in need on antiretroviral treatment, significantly expand evidence-informed HIV prevention, deal with the legacy of inequality of women and girls and care properly for millions of children orphaned by AIDS and other vulnerable children. But much more can be done now. Moving towards universal access will be possible only through urgent and concerted action by a broad political coalition to support the response to the epidemic.

In the future, historians must record that world leaders in 2006 did everything in their power to end AIDS.

I. The challenge

Seizing the momentum

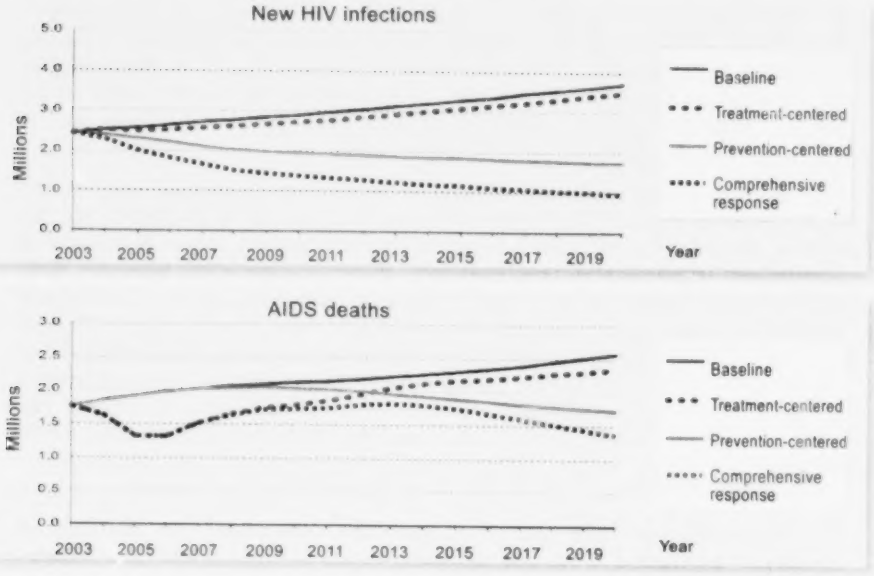
1. AIDS continues to be one of the most destructive epidemics in human history. The spread of HIV continues to outpace the global response.[1] Important progress, however, has been achieved in the last five years. The adoption of the Declaration of Commitment on HIV/AIDS in June 2001 of the twenty-sixth special session of the General Assembly[2] was a watershed moment when the world recognized the challenge posed by AIDS and pledged to take action.

2. A strong foundation has been built on the Declaration of Commitment. The Global Fund to Fight AIDS, Tuberculosis and Malaria was established to provide low- and middle-income countries with additional financing. More domestic and international resources have been mobilized. Prices of some AIDS medicines have been greatly reduced, and the "3 by 5" initiative helped to mobilize a substantial increase in people on antiretroviral treatment. The "Three Ones" principles for the coordination of AIDS responses and the recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors are improving the efficiency and effectiveness of resource utilization. The Unite for Children, Unite against AIDS campaign is putting children affected by AIDS at the centre of the AIDS agenda. This foundation lies within larger international efforts to quicken the pace of development and end poverty.[3]

3. Major steps have been taken in recent years, especially in the expansion of treatment. The number of people on antiretroviral therapy in low- and middle-income countries nearly doubled in 2005 alone, from 720,000 to 1.3 million.[4] However, there were 4.9 million new HIV infections in 2005 — the vast majority occurring in low- and middle-income countries.[5] At this rate of new infections, the world will only move farther away from universal access. The Millennium Development Goal of halting and reversing the spread of HIV by 2015 will also be unattainable.

4. A renewed emphasis on evidence-informed HIV prevention — guided by the internationally agreed Joint United Nations Programme on HIV/AIDS (UNAIDS) policy paper "Intensifying HIV prevention"[6] — is required within a comprehensive response, including care and support for those infected and affected by HIV. As the figure illustrates, just as the prospect of HIV treatment is a key to the success of many prevention efforts, significant progress towards universal access to treatment requires that HIV prevention programmes greatly reduce the number of new infections. Prevention makes treatment more affordable, and treatment makes prevention more effective.

Projected new adult infections and total adult deaths in sub-Saharan Africa, in millions, by 2020:
impact of three scenarios compared to baseline



Source: Salomon, J. A. et al., Integrating HIV Prevention and Treatment: From Slogan to Impact. PLoS Medicine. January 2005, vol. 2, issue 1.

AIDS: an exceptional epidemic

5. AIDS poses an exceptional threat to global progress and stability. In the last 25 years the epidemic has grown from a few isolated cases to over 65 million infections, and the number of new infections continues to grow each year. Nearly 25 million women, men and children have died, and only a fraction of the 40.3 million people living with the virus are even aware of their infection. Fewer still have access to the HIV medicines they need to stay alive.[5]

6. Lack of human rights protection, poverty and marginalization allow HIV to take root in society's most vulnerable populations. For example, there is often poor provision of services for men who have sex with men, sex workers and injecting drug users as a result of discrimination and political and social taboos. Young people and women are particularly vulnerable to infection due to their lack of economic and social power and autonomy in their sexual lives. They are often denied the tools and information required to avoid infection and cope with AIDS. Women and girls make up 57 per cent of all people infected with HIV in sub-Saharan Africa, where a striking 76 per cent of young people (aged 15-24 years) living with HIV are female.[5]

7. AIDS poses unique challenges for health and social systems. Moving towards universal access requires systems that can sustain services to prevent and treat HIV on an everyday basis. In many low-income countries, public health, education and

other social service systems are already buckling under the weight of sickness and death from AIDS, and skilled workers are leaving for better opportunities elsewhere.

8. AIDS is a social and cultural issue. Confronting the epidemic requires discussion and action on issues that some societies find uncomfortable, such as gender equality, sexual and reproductive health, sex work, homosexuality and injecting drug use.

9. AIDS is a health issue. Confronting the epidemic requires a stronger integrated response to AIDS, tuberculosis and other diseases, stronger primary health care, stronger maternal health care, stronger sexual and reproductive health programmes and stronger paediatric care.

10. AIDS is a development issue. The spread of HIV is both a cause and a consequence of poverty. Confronting the epidemic requires stronger action on education, nutrition and child survival.

11. AIDS is a human security issue. In countries where nearly half of the adult population is living with HIV, the political, economic and social security of the country is threatened.

12. If left on its current course, AIDS will prevent achievement of the Millennium Development Goals in highly affected countries and will place more and more countries at risk of social and political instability.

Quickening the pace

13. As requested by the General Assembly in its resolution 60/224, the UNAIDS secretariat and co-sponsors have assisted in facilitating inclusive, country-driven processes to identify practical actions for scaling up AIDS services towards universal access. Thousands of people from all walks of life quickly mobilized to seize this extraordinary opportunity. More than 100 low- and middle-income countries have held broad public debates about what needs to be done to turn back the epidemic. Seven regional consultations were held. The UNAIDS secretariat also convened a multipartner Global Steering Committee.[6]

14. Diverse definitions for the phrase "as close as possible to universal access" emerged from the consultations. The provision of HIV prevention, treatment, care and support services to all who need them is an extremely ambitious goal that has seldom, if ever, been achieved, even in high-income countries. Nonetheless, the concept of universal access implies that all people should be able to have access to services and information.

15. The urgent need to quicken the pace of the AIDS response has been highlighted in the Secretary-General's new report entitled "The Declaration of Commitment on HIV/AIDS: five years later" (A/60/736). On the basis of country progress reports on the implementation of the Declaration of Commitment, that report states that many countries have failed to fulfil their pledges. Progress is uneven among countries and regions, and within countries there is variable progress on individual targets and milestones. Some have made great strides in expanding access to treatment but have made little progress in bringing HIV prevention programmes to scale, while other countries experiencing a reduction in national HIV

prevalence are making only slow progress on treatment. According to the Secretary-General's report, several important global targets for 2005 set in the Declaration of Commitment were not met.

II. Recommendations from the consultations

16. The present section of the assessment consolidates, though not exhaustively, the results of country, regional and global consultations into an analysis of major obstacles to scaling up HIV prevention, treatment, care and support. On the basis of that analysis, UNAIDS has identified the major requirements to overcome these obstacles and recommended specific actions to help meet those requirements. At the end of each specific recommendation, a suggested deadline for its implementation has been included.

Setting and supporting national priorities

1. No credible, costed, evidence-informed, inclusive and sustainable national AIDS plan should go unfunded.

1.1. National AIDS authorities and their partners, with the full participation of all stakeholders, should develop or adapt prioritized and costed AIDS plans that are aligned with national development plans and that are ambitious but feasible for reaching their targets for moving towards universal access. (December 2006)

1.2. The UNAIDS secretariat, the United Nations Development Programme (UNDP) and the World Bank will facilitate a participatory process to provide criteria for the development and oversight of prioritized, costed, aligned and evidence-informed national AIDS plans. (December 2006)

1.3. National Governments should ensure that the impact of AIDS is included in the core indicators for measuring progress in implementing national development and poverty-reduction plans. (December 2007)

1.4. National Governments, with the assistance of the International Monetary Fund and the World Bank where needed, should initiate a transparent and inclusive dialogue with all stakeholders to ensure that fiscal space is created for AIDS spending as high-priority social expenditure. (December 2007)

1.5. Once a credible and sustainable plan is in place, conditions on donor funding for national AIDS programmes should be reduced to those that relate to good governance, fiduciary safeguards and the effective use of these funds to achieve national objectives. (December 2006)

17. The need for credible, sustainable AIDS plans as the basis for national budgetary allocations and international donor financing was a central theme throughout the consultations. The Middle East and North Africa consultation reported that there were few national AIDS plans with multisectoral involvement in the region. All regional consultations and the Global Steering Committee stressed the importance of civil society participation at every stage of planning,

implementation and monitoring, including public financial management and tracking of expenditures.

18. While recognizing the importance of promoting sustainability, maintaining macroeconomic stability and fostering rapid growth, Global Steering Committee members from low-income countries reported that excessively tight deficit-reduction and inflation-reduction targets constrain the hiring and retention of the doctors, nurses, community health-care workers, teachers and administrators who are needed to scale up. The Africa consultation, along with many Global Steering Committee members, called for international finance institutions, health and finance ministries, national AIDS authorities and civil society to adjust macroeconomic and fiscal frameworks to address the reality of AIDS.

19. Once a credible and sustainable plan is in place, limiting conditions imposed by donors to generally agreed areas such as governance, financial accountability and sustainability would quicken the utilization of funding and support greater alignment with national priorities. The Africa consultation called for an end to all conditionality except normal fiduciary requirements.

Predictable and sustainable financing

2. Meet AIDS funding needs through greater domestic and international spending and enable countries to have access to predictable and long-term financial resources.

2.1. National Governments and international donors should significantly increase the financial resources available for AIDS by strengthening and fulfilling existing commitments,[7] by fully supporting the Global Fund to Fight AIDS, Tuberculosis and Malaria and by supporting other innovative financing mechanisms,[8] for both public-sector and non-governmental providers of AIDS interventions. (Immediate and ongoing)

2.2. International donors and partner countries should adhere to the "Three Ones" principles[9] and implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors for the efficient and effective use of financial resources, including through alignment to national priorities. (December 2006)

2.3. The UNAIDS secretariat, with the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria, should commission a group of experts to explore, in collaboration with existing replenishment mechanisms, options to make domestic and international funding for AIDS more long-term and predictable. (June 2007)

20. Financial resources available for AIDS today fall far short of what is needed to move towards universal access. UNAIDS estimates that the amount needed for an expanded response in low- and middle-income countries will increase from $14.9 billion in 2006 to $22.1 billion in 2008.[10] Financial resource needs for AIDS are increasing over time for two main reasons: first, increasing numbers of people living with HIV are falling ill, and second, spending is increasing as AIDS programmes are expanding to serve more of those in need.

21. On the basis of current estimates of commitments, there may be annual resource gaps of as much as $6 billion in 2006 and $8 billion in 2007. To close the gap, existing domestic financing and international donor commitments must be fulfilled and new ones made, and innovative financing mechanisms should be supported to tap new sources of funding.

22. A long-term effort to end AIDS depends on an increase in public expenditure by low- and middle-income countries. Domestic spending — estimated at $2.8 billion in 2006, or 31 per cent of total available AIDS funding — has risen in recent years, but remains insufficient. Middle-income countries, in particular, can expand domestic spending on their AIDS responses. Participants in the Africa consultation called on the African Union to mobilize its member States to fulfil the financing target of the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. In that Declaration, African nations committed to allocating at least 15 per cent of their annual budgets to improve the health sector, including in respect of AIDS.

23. In low-income countries, official development assistance will continue to be the main source of AIDS financing. Many low- and middle-income countries, strongly supported by civil society and people living with HIV, called for full funding of the Global Fund to obtain the resources that countries need to scale up AIDS programmes. Additional resources that are needed for United Nations organizations to provide greater technical assistance to countries.

24. The Bahamas, Burkina Faso, Chad, Ethiopia, Ghana, Kenya, Kyrgyzstan, Lebanon, Malaysia, Nigeria, the Republic of Moldova, Romania, South Africa, Tajikistan, Togo and Turkey were among many countries that highlighted insufficient or unpredictable financial resources as major constraints. Global Steering Committee members called for long-term domestic and international investment to enhance the continuity of AIDS interventions and build institutional capacity.

25. Efforts to mobilize resources should be supplemented by better tracking of AIDS expenditures, which should be carried out with involvement of the full range of stakeholders. The Mali and Nigeria consultations highlighted the importance of estimating national funding needs and tracking and publicly reporting AIDS funding and expenditures.

Strengthening human resources and systems

3. Adopt large-scale measures to strengthen human resources to provide HIV prevention, treatment, care and support and to enable health, education and social systems to mount an effective AIDS response.

3.1. Countries should adopt, where needed, alternative and simplified delivery models to strengthen the community-level provision of HIV prevention, treatment, care and support, including measures to enable the shifting of tasks such as the prescribing of drugs, HIV testing and counselling, and behaviour change communication to nurses, educators and community workers, including people living with HIV. (June 2007)

3.2. **National Governments and international donors should take measures, where needed, to retain and motivate health workers, educators and community workers, including through better wages, housing, benefits and safe and secure working conditions. (June 2007)**

3.3. **National Governments and international donors should increase financing for training and accreditation centres in countries facing severe human resource shortages. (December 2007)**

3.4. **National Governments should greatly expand their capacity to deliver comprehensive AIDS programmes in ways that strengthen existing health and social systems, including by integrating AIDS interventions into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, nutrition, orphans and vulnerable children, as well as formal and informal education. (December 2008)**

26. The lack of human resources for health, education and social services heads the list of obstacles to expanding AIDS programmes in most low-income countries. The Africa consultation left no doubt that this shortage is at crisis levels on that continent. Numerous consultations in Africa — including those in Botswana, Eritrea, Ethiopia, Ghana, Kenya, Mali, Mauritius, Nigeria, Somalia and Togo — stressed that moving towards universal access in their countries is not possible without bold measures to address severe shortages of people to deliver AIDS services.

27. Lack of human resource capacity is not an issue for Africa alone. A shortage of health human resources was cited as a primary obstacle to the delivery of antiretroviral therapy and other HIV interventions in consultations in Albania, Armenia, Bangladesh, Barbados, Belize, Bulgaria, Guyana, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Republic of Moldova, Sri Lanka and Suriname and the former Yugoslav Republic of Macedonia.

28. A common thread among regional consultations in Africa and the Commonwealth of Independent States and consultations in countries hardest hit by AIDS was that many health-care providers, teachers, judges and social-sector workers suffer from demotivating working environments and salary levels, making it difficult for some countries to retain their skilled personnel. In some countries, remuneration levels are below subsistence levels. This problem is exacerbated by the much higher salaries in high-income countries, which increasingly rely upon skilled workers from the South to deliver health services.

29. The Ghana, Kenya and Philippines consultations reported that low pay and difficult working conditions were causing emigration of nurses, pharmacists and doctors in record numbers. The Guyana, Lesotho, Mongolia, Rwanda, Sudan and United Nations-administered province of Kosovo consultations identified the need to offer improved remuneration to retain skilled workers in the public sector.

30. The consultations consistently stressed that scaling up AIDS programmes requires robust, flexible health and social systems. Country consultations, particularly in Africa, reported how the epidemic is increasing the demands on already strapped systems. The Africa consultation recommended stronger links between AIDS interventions and wider health, education and social services. HIV prevention, treatment, care and support must be provided alongside and, wherever possible, through sexual and reproductive health programmes, mother and child

health services and treatment services for tuberculosis and other opportunistic infections.

31. The Global Steering Committee called for an integrated approach through broad "implementation partnerships" involving government (ministries of finance, health and education, local government and public service commissions), representatives of civil society, faith-based organizations, professional associations and labour unions, and private sector employers, as well as flexible funding for the district, local and community levels. The Committee emphasized the need for national Government and international donors to establish special budgeting at the country level for human resources through medium-term human resource strategic frameworks.

32. The implementation of alternative, lower-cost human resource models for the delivery of HIV prevention, treatment, care and support — including the deployment of auxiliary and community workers and engaging people living with HIV in the development and delivery of services — is urgently required in some countries. Global Steering Committee participants called for innovative delivery models that utilize community capacity and the resourcefulness of people living with HIV, with professional capacity-building and backstopping when needed.

33. The Albania consultation called for the national AIDS programme to begin training people living with HIV in self-care, palliative care and nursing care. The Africa consultation called for the innovative use, without sacrificing quality, of Africa's available human resources, including those within civil society. The Madagascar and Sudan consultations requested international assistance to strengthen national and regional training programmes, including for non-medical personnel.

34. Lessons learned from Malawi in the areas of task-shifting and creative retention policies were cited in the Africa consultation and the Global Steering Committee. The Malawi Government is working with donors to implement a six-year emergency programme for strengthening human resources in the health sector.

Affordable commodities

4. Remove major barriers — in pricing, tariffs and trade, regulatory policy, and research and development — to speed up access to affordable, quality HIV-prevention commodities, medicines and diagnostics.

4.1. National Governments, where needed, should remove legal, regulatory or other barriers that block access to effective HIV-prevention interventions and commodities such as condoms and harm reduction.[11] (June 2007)

4.2. The United Nations Population Fund, the United Nations Children's Fund and the World Health Organization (WHO) — in collaboration with existing global and regional procurement facilities, and by promoting informed demand forecasting and bulk procurement, differential pricing and, where appropriate, voluntary licensing — will help lower prices for HIV prevention and treatment commodities, including second- and third-line antiretrovirals. (Immediate and ongoing)

4.3. **Countries should reform their legislation and tax codes, where needed, to exempt HIV prevention and treatment commodities, including HIV medicines, from all taxes and tariffs. (June 2007)**

4.4. **National Governments, with support from international partners and multilateral organizations, should employ, where needed, the flexibilities in the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to secure access to a sustainable supply of affordable HIV medicines and essential health technologies, including through local production, where feasible. (December 2007)**

4.5. **Countries should reform their legislation and regulations, as necessary, to allow medicines pre-qualified by WHO, or medicines approved by other widely recognized stringent drug regulatory bodies, to obtain provisional marketing approval to allow access to life-saving HIV medicines and diagnostics prior to full registration by national drug regulatory authorities. (Immediate and ongoing)**

4.6. **Pharmaceutical companies, international donors, multilateral organizations and other partners should develop public-private partnerships to promote quicker development of paediatric antiretroviral formulations and other medicines, and new HIV-related pharmaceutical products (HIV vaccines, microbicides). (Immediate and ongoing)**

35. Nearly all consultations stressed that the availability of affordable HIV-related commodities — including quality medicines and diagnostics, male and female condoms, other HIV-prevention technologies and nutritional support for children and adults affected by AIDS — is critical to scaling up comprehensive AIDS services.

36. Male latex condoms should be provided free or at low cost and their use actively promoted as part of a comprehensive prevention programme. Given the "feminization" of the epidemic, expanding the provision of female condoms and accelerating the development of microbicides are crucial.

37. Increasingly, people on HIV treatment will need to switch from first-line antiretrovirals to second- and third-line combinations. Few simple and palatable antiretrovirals are available to treat children. The prices of newer medicines and some viral monitoring equipment remain high. The Asia and the Pacific and Latin America consultations expressed concern that countries in their regions are unable to procure patented HIV medicines at affordable prices.

38. Consultations in Latin America, Africa and Asia and the Pacific called for support for countries to use the flexibilities in the WTO TRIPS Agreement, such as compulsory licensing, to enhance access to affordable generic HIV medicines. Concern was expressed that some low- and middle-income countries are opting for more extensive patent protection than required under the WTO intellectual property rules. Many Global Steering Committee members and the regional consultations in Latin America and Africa called for a programme to support countries in utilizing these flexibilities. The regional consultations in Africa, Asia and the Pacific and South-Eastern Europe called for the establishment of regional mechanisms for price negotiations and procurement.

39. HIV-related commodities are subject to taxes and tariffs in many countries, increasing their prices. Efforts to eliminate these taxes and tariffs as soon as possible were widely urged throughout the consultative process.

40. Reports from a number of national consultations showed that increasing numbers of countries are seeking local production capacity for HIV medicines. Consultations called for greater local production to increase the number of suppliers and enhance generic competition, where local production is economically viable.

41. National laws may create barriers in access to effective HIV prevention interventions and commodities, such as harm reduction measures for injecting drug users. Regional consultations in Latin America, Asia and the Pacific, the Commonwealth of Independent States, and the Middle East and North Africa all called attention to the importance of addressing barriers in access to evidence-informed prevention interventions. Country consultations in Kazakhstan, Mauritius, the Republic of Moldova, the Russian Federation and elsewhere reported legal barriers to the distribution of HIV-related commodities.

42. The Global Steering Committee identified delays in the regulatory approval of new products as a major obstacle in making HIV treatment and prevention technologies rapidly available to users. Countries are not yet taking full advantage of the WHO pre-qualification process, or qualification by other stringent drug regulatory authorities, to expedite the availability of HIV-related medicines and commodities on a provisional basis prior to full approval by the respective country regulatory authorities.

43. The Africa and Latin America consultations identified weak procurement and distribution systems as a continuing challenge in respect of the availability of HIV prevention, diagnosis and treatment commodities. Poor information and demand forecasting within health systems limit collective regional and global efforts to negotiate lower prices and can result in inadequate supply.

Stigma, discrimination, gender and human rights

5. Protect and promote the AIDS-related human rights of people living with HIV, women and children, and people in vulnerable groups,[7] and ensure that they are centrally involved in all aspects of the response.

5.1. National Governments and international donors should prioritize funding for social mobilization campaigns in local languages to protect and promote AIDS-related rights and eliminate HIV-associated stigma and discrimination. (Immediate and ongoing)

5.2. National Governments and international donors should increase funding for programmes to address gender inequalities that fuel the epidemic among women and girls, reform and enforce legislation, where needed, to protect women and girls from harmful traditional practices and from sexual violence in and outside marriage and ensure equality in domestics relations, including in respect of property and inheritance rights of women and girls. (Immediate and ongoing)

5.3. **National Governments should, where needed, establish and enforce legislation and policies to eliminate AIDS-associated stigma and discrimination against people living with HIV, injecting drug users, sex workers, men who have sex with men and other vulnerable populations. (December 2007)**

5.4. **National Governments and international donors should increase funding for networks and organizations of people living with HIV to provide HIV prevention and treatment literacy[13] campaigns in local languages aimed at increasing awareness and improving the delivery of HIV prevention and treatment. (Immediate and ongoing)**

5.5. **Countries should promote, through global and national campaigns, the ideal that each person knows his or her HIV status and has access to AIDS information, counselling and related services, in a social and legal environment that is supportive and safe for confidential testing[14] and voluntary disclosure of HIV status. (December 2006)**

5.6. **Countries should promote equitable access to AIDS interventions by reviewing their health system policies to reduce or eliminate user fees for AIDS-related prevention, treatment, care and support. (June 2007)**

44. Country and regional consultations consistently reported that legal, social and cultural barriers are undermining access to interventions for those most at risk of HIV infection and most affected by AIDS. Violence against women, drug users, sex workers and men who have sex with men and other HIV-related human rights abuses are still widespread. However, HIV-related human rights are not high enough among the priorities of national Governments, donors or human rights organizations.

45. Many people fear that seeking AIDS-related information and services will brand them as social outcasts and expose them to discrimination, rejection or even violence from their families and communities. The country consultation in Ghana reported that continuing stigma attached to AIDS prevents many Ghanaians from seeking access to HIV counselling, testing, and treatment and care services. Many regional and country consultations identified homophobia, gender inequalities and discrimination against people in vulnerable groups as major barriers.

46. The low status of women in many societies fuels the transmission of HIV and worsens its impact. The Africa consultation emphasized that scaling up towards universal access would not be possible on that continent without a central focus on the needs of women and girls. The Middle East and North Africa consultation reported that gender inequality, discriminatory laws, and stigma and discrimination were constraining AIDS programmes. At the country consultation in Pakistan, participants reported that gender discrimination was blocking access to health services. The Asia and the Pacific consultation called attention to the fact that marriage and women's own fidelity are not enough to protect them against HIV infection. The Global Steering Committee emphasized that women and girls do not have widespread access to HIV-protective methods they can easily afford, initiate and control. Female condoms are not yet widely accessible, and far greater urgency is required in the development of new prevention technologies such as microbicides.

47. Many consultations stressed that the development and enforcement of supportive laws and protection of human rights — including the rights of women and children — must remain priorities. The Asia and the Pacific consultation called

on Governments in the region to review legislation that is inconsistent with national AIDS-control policies. The need for new laws that protect people living with HIV and members of vulnerable groups, or the strengthening and enforcement of existing legislation, was noted at the country consultations in Bosnia and Herzegovina, the Dominican Republic, Ghana, the Democratic Republic of the Congo, Haiti, Madagascar, Nigeria, the Russian Federation, Senegal, Swaziland, Sierra Leone and the United Nations-administered province of Kosovo.

48. Increasing the number of people who know their HIV status is critical for reaching more people in need of treatment, preventing mother-to-child transmission and providing intensive prevention services, especially for discordant couples. Civil-society participants in national, regional and global consultations emphasized that HIV testing must be informed and voluntary. Insufficient access to confidential HIV testing was cited in consultations in Albania, Bangladesh, Botswana, Cambodia, Ethiopia, Gabon, Papua New Guinea, the Republic of Moldova, Romania, Somalia, Suriname, the former Yugoslav Republic of Macedonia, Trinidad and Tobago and the United Nations-administered province of Kosovo. Some high-burden countries reported that they now routinely offer HIV testing to patients in all clinical and community-based health-service settings.

49. Greater resources and political commitment must be mobilized to address problems of stigma, discrimination, gender and human rights. Two specific approaches that received support in the consultations were social mobilization campaigns and efforts to increase the involvement of people living with HIV in the provision of prevention and treatment literacy messages.

50. Numerous consultations identified user fees for health and education as an obstacle restricting access, especially for people living below the poverty line. Even small user fees can impose a significant financial burden on individuals and families and undermine adherence to HIV treatment regimens and the use of prevention commodities. Countries such as Botswana, Brazil, Ethiopia, Senegal, Thailand, the United Republic of Tanzania and Zambia have all adjusted health-financing policy to eliminate user fees for HIV treatment at the point of service delivery.[4]

51. The country consultation in China applauded the Government's new "Four Frees and One Care" policy, which calls for free antiretroviral therapy for rural residents or people with financial difficulties living in urban areas; free voluntary counselling and testing; free services to prevent mother-to-child transmission and HIV testing of newborn babies; free schooling for children orphaned by AIDS; and care and economic assistance for affected households.

Targets and accountability

6. Every country should set in 2006 ambitious AIDS targets that reflect the urgent need to massively scale up HIV prevention, treatment, care and support and move as close as possible to the goal of universal access by 2010.

6.1. Every country should develop action plans to reach by 2008 at least 50 per cent of its 2010 targets. (December 2006)

6.2. The UNAIDS secretariat and WHO will provide countries with a small set of key indicators and guidelines to help set national targets and measure progress towards the goal of universal access. (Immediate and ongoing)

6.3. **Countries should ensure the accountability of all partners through transparent peer-review mechanisms for the public monitoring of targets and regular reporting of country and regional progress towards the goal of universal access. (Immediate and ongoing)**

6.4. **Countries should establish inclusive and transparent national processes, involving parliaments and civil society, for public financial management and expenditure tracking to verify the allocation, use and impact of AIDS funding. (Immediate and ongoing)**

6.5. **National Governments, international donors, United Nations agencies, civil society and other stakeholders should ensure mutual accountability at the country level through participatory reviews of national AIDS responses. (June 2007)**

52. The consultations widely agreed that improved accountability mechanisms are crucial to motivate, sustain, measure and publicly report progress towards universal access. Setting ambitious but feasible national targets for 2010, with specific and bold intermediate targets for 2008, is essential for countries to prioritize their efforts, mobilize resources and monitor and evaluate their results. If national target-setting and tracking are standardized through global guidance, the results can be aggregated to produce regional and global targets. This approach to target-setting responds to the wide range of coverage of AIDS interventions from country to country.

53. The Latin America consultation called on global-level partners to develop tools to evaluate progress towards universal access at the country and the regional level. UNAIDS, working closely with the Global Steering Committee, is proposing a limited number of existing indicators to be used by countries to set targets for scaling up towards universal access (see annex). Guidelines for target-setting and a scorecard for tracking and reporting progress will be rapidly developed by the UNAIDS secretariat and WHO.

54. As agreed at the Africa consultation, any target-setting process should involve key stakeholders within government and civil society, preferably with existing national mechanisms such as national AIDS authorities, country coordinating mechanisms and national partnership forums. The tracking and reporting of progress against national targets should be inclusive and transparent.

55. Accountability can be further enhanced through public financial management and expenditure tracking that verifies the allocation, use and impact of AIDS spending. Transparency should be increased through the close involvement of parliamentarians and civil society.

56. The poor progress towards several global targets set out in the Declaration of Commitment demonstrates the need for countries to establish an adequate monitoring capacity for the timely adjustment of strategies. The Asia and the Pacific and Africa consultations called for the participation of peer review mechanisms or independent regional watchdog groups to promote ambitious target-setting, ensure transparency in country monitoring and reporting, and aggregate national targets into regional targets. The Latin America consultation supported regional tracking of progress.

57. Accountability is not limited to national Governments. United Nations agencies, international donors, civil society, governments and other stakeholders must be mutually accountable for fulfilling international commitments. The tracking of adherence to internationally agreed frameworks for harmonization and alignment could be enhanced through participatory review mechanisms and a scorecard-style accountability tool.

58. At the global level, UNAIDS should aggregate country targets into global targets, compile country and regional data to track progress towards universal access and provide annual reports within existing reporting mechanisms. Special annual reports on progress towards universal access must be made available to relevant multipartner meetings and the governing bodies of international organizations.

III. Conclusion

59. **The country, regional and global consultations have produced important recommendations for rapidly and dramatically improving the quality and scale of HIV prevention, treatment, care and support interventions and coming as close as possible to universal access.**

60. **At the comprehensive review and high-level meeting on AIDS, to be held from 31 May to 2 June 2006, world leaders will have the opportunity to set an ambitious global agenda to fulfil the commitments they have made. Moving towards universal access will require the world to overcome many obstacles. It will not be easy to break the vicious cycle of new HIV infections, put millions of people in need on antiretroviral treatment and care properly for millions of children orphaned by AIDS and other vulnerable children. But in the future, historians must record that world leaders in 2006 did everything in their power to end AIDS.**

Notes

[1] See A/60/736.

[2] Resolution S-26/2, annex.

[3] These include the High-level Forum on Health-related Millennium Development Goals; the Education for All initiative; the Monterrey Consensus; the Paris Declaration on Aid Effectiveness; progress by developed countries to reach the United Nations target of 0.7 per cent of their gross national income for official development assistance; and the Brussels Programme of Action for the Least-Developed Countries.

[4] WHO/UNAIDS, *Progress on Global Access to HIV Antiretroviral Therapy: A Report on "3 by 5" and Beyond*, March 2006.

[5] UNAIDS, *AIDS Epidemic Update*, December 2005.

[6] "Intensifying HIV prevention" was endorsed on 29 June 2005 by the Programme Coordinating Board of UNAIDS. This policy paper identifies the following essential programmatic actions for HIV prevention: prevent the sexual transmission of HIV; prevent mother-to-child transmission of HIV; prevent the transmission of HIV through injecting drug use, including harm reduction measures; ensure the safety of the blood supply; prevent HIV transmission in health-care settings; promote greater access to voluntary HIV counselling and testing while promoting principles of confidentiality and consent; integrate HIV prevention into AIDS treatment services; focus on HIV prevention among young people; provide HIV-related information and

education to enable individuals to protect themselves from infection, confront and mitigate HIV-related stigma and discrimination, and prepare for access to and use of vaccines and microbicides.

[7] See, e.g., Group of Eight commitments to increase official development assistance; the European Union pledge to commit an average of 0.56 per cent of national wealth for aid by 2010 and 0.7 per cent by 2015; the Monterrey Consensus; and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Special attention should be given to countries in conflict and post-conflict situations.

[8] Examples of innovative financing mechanisms mentioned during the Global Steering Committee consultations included the establishment of an International Finance Facility, the international solidarity contribution on airline tickets and various debt relief and debt conversion mechanisms.

[9] The internationally agreed "Three Ones" principles call for the coordination of a national AIDS response around one agreed AIDS action framework, one national coordinating authority (including government, civil society, people living with HIV and the private sector) and one agreed country-level monitoring and evaluation system.

[10] UNAIDS, "Resource needs for an expanded response to AIDS in low- and middle-income countries", August 2005.

[11] "Intensifying HIV prevention" states that preventing transmission of HIV through injecting drug use requires "a comprehensive, integrated and effective system of measures that consists of the full range of treatment options (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary health care and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users". In its endorsement of this document, the Programme Coordinating Board noted that the United States of America could not fund needle and syringe programmes as they are inconsistent with United States law and policy, and noted that this external partner cannot be expected to fund activities inconsistent with its own national laws and policies. Japan has also stated harm reduction programmes are inconsistent with its domestic policy.

[12] In this assessment, "populations most vulnerable to HIV exposure", "vulnerable groups", "most affected communities" and similar phrases include men who have sex with men, injecting and other drug users, sex workers, people living in poverty, prisoners, migrant labourers, people in conflict and post-conflict situations, and refugees and internally displaced persons.

[13] HIV "prevention and treatment literacy" refers generally to the possession of knowledge, skills and attitudes based on sound scientific evidence for people living with HIV to actively participate in their own prevention and treatment decisions and to contribute to the training of other HIV-positive people and members of their communities.

[14] The UNAIDS/WHO Policy Statement on HIV Testing states that testing of individuals must be confidential, accompanied by counselling, and with informed consent.

Annex

Selection of targets based on existing indicators

The following existing indicators are suggested as core and recommended indicators for determining national targets for moving towards universal access. Most countries are collecting information for these indicators as part of the monitoring of progress towards the implementation of the Declaration of Commitment on HIV/AIDS and the Millennium Development Goals. These indicators can serve to inform the selection of targets for 2008 and 2010, so that progress in all countries to achieve their targets can be monitored according to this common set of indicators. Core indicators should be used by all countries. Recommended indicators can be included to provide supplemental information on progress towards universal access.

Core indicators

Treatment

1. Percentage of women, men and children with advanced HIV infection who are receiving antiretroviral combination therapy.

Care and support

2. Percentage of orphans and vulnerable children (boys/girls) aged under 18 living in households where a basic external support package has been received.

Prevention

3. Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.

4. Percentage of general population or populations most at risk who received an HIV test in the past 12 months and were informed of the results.

5. Number of condoms distributed annually by the public sector and the private sector.

6. Percentage of young men and women aged 15 to 24 who have had sex before age 15.

National commitment

7. Amount of national funds disbursed by Governments in low- and middle-income countries.

Recommended indicators

Treatment

1. Percentage of adults and children with advanced HIV infection who are still alive 12 months after initiation of combination antiretroviral therapy.

Prevention

2. Percentage of young people (15-24) or members of groups at risk who correctly identify ways of preventing sexual transmission of HIV — including delaying sexual debut, reducing number of partners and using condoms — and reject major misconceptions (male/female).

3. Percentage of populations most at risk reached by prevention programmes.

National commitment

4. Monitoring the implementation of the "Three Ones" principles, using the UNAIDS country checklist.